

Patient Information Sheet



Child / Adolescent Details

Surname: _____

First name(s) _____

Date of birth: _____

School: _____

Other agencies / helping professionals currently involved (e.g. GP, Paediatrician, School Counsellor)

Parent / Guardian Details

Name (s): _____

Address: _____

Telephone (home): _____ (mobile): _____ (work): _____

Email: _____

Relationship to child / adolescent: _____

Referring person / agency

Name: _____

Address: _____

Telephone: _____

How did you hear about us? Doctor / friend / internet search / other: _____

Health Insurance

Fund name: _____

Medicare No.: _____

Ref No. on Card: _____



Information & Consent Form

Welcome Sleep Matters (administered through to Jeffery&Ree Clinical Psychologists). We provide clinical psychology services for children and adults and a specialised sleep services. We look forward to proving you with top quality care. Please read this information and sign to indicate your agreement.

Confidentiality

In order to provide your child with the highest standard of psychological care, personal & health information that is relevant to their current situation will be recorded. Client files are either paper-based and held in a secure filing cabinet that is only accessible by Jeffery&Ree/Sleep Matters Clinical Psychologists, or, are electronic and stored securely on our practice management system which meets industry e-security requirements.

All personal information gathered during the provision of psychological service will remain confidential and secure except when: it is subpoenaed by a court, failure to disclose the information would put your child or another person at risk, or your prior approval has been obtained to provide information to another professional, agency, or person (e.g., spouse, parent, employer).

Request for access to personal information

You may request to see the information about your child that is kept on file. You may access the material recorded in the file, subject to exceptions in National Privacy Principle 6. Requests by you for access to information will be responded to within 14 days and an appointment will be made if necessary for clarification purposes.

Communication with your GP and/or other referring doctor.

If your child was referred by a medical practitioner, your psychologist will communicate with them regarding your treatment. This will usually be in the form of assessment and progress letters and phone contact as needed. Written permission is required if you would like to have any other health professionals or third parties included in these communications.

Concerns about management of personal information

If you have a query or concern about the management of your child's personal information, please do not hesitate to ask. The National Privacy Principles (www.privacy.gov.au), describe your rights and how your information should be handled. Ultimately if you wish to make a formal complaint about the management of your personal information, you may do so with the Office of the Federal Privacy Commissioner on 1300 363 992.

Fees

The cost of 50 minute consultations are as follows:

- **Clinical psychologist registrar: \$160** (Medicare rebate for those with GP care plan or psychiatry referral is \$86.15)
 - **Clinical psychologist: \$200-\$220** (Medicare rebate for those with GP care plan or psychiatry referral is \$126.50)
- **Fees are payable on the day of consultation** by *Eftpos, credit card, cash, or money order.*
- If you have a GP mental health care plan referral, psychiatrist, or paediatrician referral, you may be eligible for a Medicare rebate (leaving a gap of \$73.85-\$93.50 per session). Please check with your doctor to see if you are eligible.
- Please bring any referrals to your first appointment.
- If you are not eligible for Medicare and have private health insurance cover for psychology, please contact your private health insurer in order to check the level of rebate you are eligible for.
- You can claim Medicare rebates after each session via the Medicare App:
<https://www.humanservices.gov.au/customer/services/express-plus-mobile-apps>.

Cancellation Policy

Appointments are precious. If you need to cancel an appointment, if at all possible, please provide **at least 48 hours notice**. A **cancellation fee of \$50 will be applied if you cancel with less than 48 hours notice**. The full fee is charged if you fail to attend an appointment. We'd rather not have to charge for missed appointments if there is an alternative so please do notify us if you need to change or cancel. Cancellation fees cannot be claimed from Medicare or your private health insurer.

Availability

You can make changes to your appointment times Monday-Friday 9am-5pm by phoning the practice reception service on **6107 6828**. If you would like to speak with your psychologist, please leave a message with the practice reception, and your psychologist will endeavour to return your call within 24 hours (other than when they are on annual leave). If the matter is urgent and you have been unable to contact your psychologist, please call your either your psychiatrist, GP, or an emergency help-line such as Crisis Care (9223 1111).

I (please print name) _____ have read and understood the above information. I agree to these conditions for the psychological service provided by Ree & Jeffery Clinical Psychologists.

Signature: _____ Date: _____

Insomnia Severity Index

1. Please rate the current (last 2 weeks) **severity** of your sleep problems (for all questions rate '0' if your sleep has not been a problem).

	<u>None</u>	<u>mild</u>	<u>moderate</u>	<u>severe</u>	<u>very severe</u>
Difficulty falling asleep	0	1	2	3	4
Difficulty staying asleep	0	1	2	3	4
Problem waking too early	0	1	2	3	4

2. How satisfied/dissatisfied are you with your current sleep pattern?

Very satisfied		moderately satisfied		very dissatisfied
0	1	2	3	4

3. To what extent do you consider problems with sleep **interfere** with your daily functioning (e.g., daytime fatigue, ability to function at work/daily chores, concentration, memory, mood etc?).

Not at all	a little	somewhat	much	very much
0	1	2	3	4

4. How **noticeable** to others do you think your sleeping problem is in terms of impairing the quality of your life?

Not at all	a little	somewhat	much	very much
0	1	2	3	4

5. How **worried/distressed** are you about current sleep problem?

Not at all	a little	somewhat	much	very much
0	1	2	3	4

Thank you for your time.

If you are attending for assistance with sleep, please also complete the **7 day sleep log (see website)**. Please bring this paperwork, and your referral/care plan (if you have one) with you to your first session. We look forward to working with you.

Strengths and Difficulties Questionnaire

P or T¹¹⁻¹

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of this young person's behavior over the last six months or this school year.

Young person's name

Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other youth, for example books, games, food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often loses temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Would rather be alone than with other youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally well behaved, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries or often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other youth or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, depressed or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often offers to help others (parents, teachers, children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets along better with adults than with other youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good attention span, sees work through to the end	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature

Date

Parent / Teacher / Other (Please specify):

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behavior or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes", please answer the following questions about these difficulties:

• How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties upset or distress your child?

Not at all	Only a little	A medium amount	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	A medium amount	A great deal
HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLASSROOM LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	A medium amount	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature

Date

Mother/Father/Other (please specify:)

Thank you very much for your help

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Please now download and complete the 7-day sleep log and bring it with you to your first appointment.